FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029199

Facility Name: BURGESS SQUARE HEALTHCARE CTR

Address: 5801 SOUTH CASS AVENUE (Number) WESTMONT (City) 60559 (Zip Code)

County: DUPAGE

Telephone Number: (630) 971-2645 **Fax #** (630) 971-1961

IDPA ID Number: 36-3328030001

Date of Initial License for Current Owners: 04/04/85

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACQUELINE I. MASON
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3	105	Intermediate (ICF)	105	38,325	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	207	TOTALS	207	75,555	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			7,331	7,331	8
9	SNF/PED					9
10	ICF	32,848	24,033	1,236	58,117	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,848	24,033	8,567	65,448	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.62%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 74 and days of care provided 7,331

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	352,677	35,033	50,164	437,874		437,874		437,874			1
2	Food Purchase		326,990		326,990		326,990	(29,050)	297,940			2
3	Housekeeping	335,779	70,715		406,494		406,494		406,494			3
4	Laundry	93,989	25,916	5,402	125,307		125,307		125,307			4
5	Heat and Other Utilities			210,810	210,810		210,810		210,810			5
6	Maintenance	113,574	35,608	30,223	179,405		179,405		179,405			6
7	Other (specify):*			18,044	18,044		18,044		18,044			7
8	TOTAL General Services	896,019	494,262	314,643	1,704,924		1,704,924	(29,050)	1,675,874			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,045,230	167,578	203,130	3,415,938		3,415,938		3,415,938			10
10a	Therapy	470,394	9,150	5,499	485,043		485,043		485,043			10a
11	Activities	183,247	11,294	3,599	198,140		198,140		198,140			11
12	Social Services	91,874			91,874		91,874		91,874			12
13	CNA Training											13
14	Program Transportation			218	218		218		218			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,790,745	188,022	221,446	4,200,213		4,200,213		4,200,213			16
	C. General Administration											
17	Administrative	195,619		298,976	494,595		494,595	(35,976)	458,619			17
18	Directors Fees											18
19	Professional Services			47,894	47,894		47,894		47,894			19
20	Dues, Fees, Subscriptions & Promotions			83,010	83,010		83,010	(13,989)	69,021			20
21	Clerical & General Office Expenses	129,123	52,747	91,091	272,961		272,961	14,016	286,977			21
22	Employee Benefits & Payroll Taxes			1,013,234	1,013,234		1,013,234		1,013,234			22
23	Inservice Training & Education			6,962	6,962		6,962		6,962			23
24	Travel and Seminar							57	57			24
25	Other Admin. Staff Transportation			2,130	2,130		2,130		2,130			25
26	Insurance-Prop.Liab.Malpractice			163,140	163,140		163,140	2,324	165,464			26
27	Other (specify):*							38,497	38,497			27
28	TOTAL General Administration	324,742	52,747	1,706,437	2,083,926		2,083,926	4,929	2,088,855			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,011,506	735,031	2,242,526	7,989,063		7,989,063	(24,121)	7,964,942			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BURGESS SQUARE HEALTHCARE CTR #0029199 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	40,030	
	REPAIRS & MAINTENANCE		10,134	
			0	50,164
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		4,206	
	CONTRACTED LAUNDRY SERVICES		1,196	5,402
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		68,154	
	ELECTRICITY		82,590	
	WATER		56,431	
	CABLE TV - LOBBY		3,635	
			0	210,810
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,321	
	PAINTING & DECORATING		583	
	BUILDING REPAIRS		720	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,552	
	ELEVATOR MAINTENANCE & REPAIR		9,559	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,488	
	FIRE SERVICE		0	
			0	
			0	
			0	30,223
7	**OTHER**			
	SCAVENGER		15,492	
	SECURITY SERVICE		2,552	18,044
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	166,480	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,501	
	PHARMACY CONSULTANT	XVIII B 39-2	2,149	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	30,000	
			0	
			0	203,130
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	5,499	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	5,499
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,599	
			0	3,599
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR #0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		218	218
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	298,976	298,976
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,363	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	40,531	
			0	47,894
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	12,865	
	EMPLOYEE WANT ADS	XIX F	52,121	
	CONTRIBUTIONS	VI 20 XIX F	350	
	DUES & SUBSCRIPTIONS	XIX F	2,628	
	LICENSES & PERMITS	XIX F	7,378	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	850	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	200	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	6,618	83,010
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		762	
	EQUIPMENT REPAIR & MAINTENANCE		4,041	
	OUTSIDE CLERICAL SERVICES		39,350	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		5,287	
	TELEPHONE		41,131	
	MESSENGER SERVICE		520	
			0	91,091

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	392,219	
	UNEMPLOYMENT COMPENSATION	XIX D	57,514	
	WORKERS COMPENSATION INSURANCI	XIX D	146,938	
	HOSPITALIZATION INSURANCE	XIX D	369,379	
	EMPLOYEE BENEFITS - OTHER	XIX D	15,944	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	31,240	
	CHICAGO HEAD TAX	XIX D	0	1,013,234
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,962	6,962
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,130	2,130
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		163,140	163,140
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 2,242,526

BURGESS SQUARE HEALTHCARE CTR
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	326,990	PATIENT MEALS	196344
LESS SALES TAX	(1,500)	ADD EMPLOYEE MEALS	0
NET FOOD	325,490	TOTAL MEALS/YEAR	196344
TOTAL PATIENT CENSUS	65,448	NET FOOD	325490
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	196344
TOTAL PATIENT MEALS	196344	COST PER MEAL	1.66
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR #0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			40,398	40,398		40,398	53,585	93,983			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,798	15,798		15,798	(2,329)	13,469			32
33	Real Estate Taxes			109,601	109,601		109,601		109,601			33
34	Rent-Facility & Grounds			823,987	823,987		823,987		823,987			34
35	Rent-Equipment & Vehicles			63,144	63,144		63,144		63,144			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,052,928	1,052,928		1,052,928	51,256	1,104,184			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		282,778	56,321	339,099		339,099		339,099			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			113,333	113,333		113,333		113,333			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		282,778	169,654	452,432		452,432		452,432			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,011,506	1,017,809	3,465,108	9,494,423		9,494,423	27,135	9,521,558			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	53,585	30		9
10	Interest and Other Investment Income	(2,329)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,500)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(200)	20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(350)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(12,865)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(850)	20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 35,491		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(8,356)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (8,356)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 27,135		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

BURGESS SQUARE HEALTHCARE CTR

ID# 0029199

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,500)	0	(27,550)	0	0	0	0	0	0	0	0	(29,050)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,500)	0	(27,550)	0	0	0	0	0	0	0	0	(29,050)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(35,976)	0	0	0	0	0	0	0	0	0	(35,976)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(14,265)	0	276	0	0	0	0	0	0	0	0	(13,989)	20
21	Clerical & General Office Expenses	0	0	14,016	0	0	0	0	0	0	0	0	14,016	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	57	0	0	0	0	0	0	0	0	57	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,324	0	0	0	0	0	0	0	0	2,324	26
27	Other (specify):*	0	34,364	4,133	0	0	0	0	0	0	0	0	38,497	27
28	**TOTAL General Administration**	(14,265)	(1,612)	20,806	0	0	0	0	0	0	0	0	4,929	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,765)	(1,612)	(6,744)	0	0	0	0	0	0	0	0	(24,121)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	53,585	0	0	0	0	0	0	0	0	0	0	53,585	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,329)	0	0	0	0	0	0	0	0	0	0	(2,329)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	51,256	0	0	0	0	0	0	0	0	0	0	51,256	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	35,491	(1,612)	(6,744)	0	0	0	0	0	0	0	0	27,135	45

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACQUELINE MASON	70	NA		UNITED CARE	OVANDO, MONTANA	MGMT CO
MONTY MILLER	30			MGMT PROF	CLARENDON HILLS, IL	BKKP CONSLT
				FOR HC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 298,976	UNITED CARE	100.00%	$	$ (298,976)	1
2	V								2
3	V								3
4	V	17	ADMINISTRATIVE				263,000	263,000	4
5	V	27	EMPLOYEE BENEFITS				34,364	34,364	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 298,976			$ 297,364	$ * (1,612)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	DIETARY CONSULTANT	$ 27,550	MANAGEMENT PROFESSIONALS FOR HEALTHCARE		$	$ (27,550)	15
16	V	21	OTHER PROF.-BOOKKEEPING	36,800				(36,800)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	20	DUES, SUBSCRIPTIONS				276	276	23
24	V	21	CLERICAL & GENERAL				2,122	2,122	24
25	V	24	SEMINARS				57	57	25
26	V	26	INSURANCE				2,324	2,324	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V	21	CLERICAL SALARIES				48,694	48,694	34
35	V	27	EMPLOYEE BENEFITS				4,133	4,133	35
36	V								36
37	V								37
38	V								38
39	Total			$ 64,350			$ 57,606	$ * (6,744)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACQUELINE MASON	PRESIDENT	ADMIN	70.00	N/A	40	80.00	SALARY	$ 150,000	17-7	1
2	MONTY MILLER	VICE PRESIDENT	ADMIN	30.00	N/A	35	87.50	SALARY	113,000	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 263,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL				289,452			15,798	6
7												7
8												8
9	TOTAL Facility Related						$	$ 289,452			$ 15,798	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 289,452			$ 15,798	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR **#** 0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	96,240	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	101,841	2
3. Under or (over) accrual (line 2 minus line 1).	$	5,601	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	104,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	109,601	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	88,208	8
2001	92,201	9
2002	93,444	10
2003	96,085	11
2004	101,841	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BURGESS SQUARE HEALTHCARE CTR COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0029199

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-15-107-044	NURSING HOME	$ 101,841.34	$ 101,841.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,841.34	$ 101,841.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,000 B. General Construction Type: Exterior BRICK Frame STEEL STRUCTURE Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1985	86,486		20	3,801	3,801	86,486	9
10	VARIOUS			1986	87,317	1,871	20	704	(1,167)	87,317	10
11	VARIOUS			1987	10,202	324	20	6	(318)	10,202	11
12	VARIOUS			1988	11,485	382	20	574	192	10,032	12
13	VARIOUS			1989	25,270	600	20	1,264	664	21,017	13
14	VARIOUS			1990	52,220	750	20	2,612	1,862	41,578	14
15	VARIOUS			1991	27,798	1,303	20	585	(718)	27,798	15
16	VARIOUS			1992	12,659	370	20	633	263	8,405	16
17	VARIOUS			1993	342,712	10,052	20	17,135	7,083	209,340	17
18	VARIOUS			1994	16,249	417	20	813	396	9,598	18
19	VARIOUS			1995	20,503	526	20	1,025	499	10,778	19
20	VARIOUS			1996	23,823	611	20	1,191	580	11,177	20
21	VARIOUS			1997	29,589	759	20	1,479	720	12,782	21
22	VARIOUS			1998	36,702	967	20	1,837	870	14,070	22
23	VARIOUS			1999	88,002	2,228	20	4,399	2,171	28,292	23
24	VARIOUS			2000	195,196	5,005	20	9,761	4,756	56,380	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELEVATOR IMPROVEMENT	2001	$ 2,150	$ 55	20	$ 108	$ 53	$ 539	37
38	HOT WATER TANK	2001	5,646	145	20	282	137	1,388	38
39	ROOF IMPROVEMENT	2001	11,275	289	20	564	275	2,726	39
40	DOORS	2001	1,595	41	20	80	39	380	40
41	ELECTRICAL WALL PAKS	2001	1,258	32	20	63	31	294	41
42	ELECTRICAL WORK	2001	1,795	46	20	90	44	390	42
43	CARPETS	2001	5,009		20	501	501	2,171	43
44	SIGNS	2001	3,000		20	300	300	1,300	44
45	HVAC UNIT	2001	11,500	295	20	575	280	2,444	45
46	HVAC UNIT	2001	11,500	295	20	575	280	2,396	46
47	SIGNS	2001	930		20	93	93	388	47
48	SIGNS	2001	2,526		20	253	253	1,053	48
49	PLUMBING	2001	11,314	290	20	566	276	2,310	49
50	CARPENTRY	2001	1,607	41	20	80	39	328	50
51	CALL STATION	2001	1,536		20	77	77	327	51
52	NETWORK CABLES	2001	987		20	49	49	217	52
53	TELEPHONE	2001	770		20	39	39	165	53
54	ELECTRIC RANGE	2001	1,036		20	52	52	212	54
55	CALL STATION	2001	568		20	28	28	141	55
56	TILE	2001	582		20	29	29	138	56
57	TILE	2001	1,187		20	59	59	281	57
58	TELEPHONE	2001	599		20	30	30	133	58
59	PLUMBING	2001	809		20	40	40	171	59
60	HEAT EXCHANGER	2001	1,400		20	70	70	298	60
61	TILE	2001	539		20	27	27	117	61
62	SECURITY SYSTEM	2001	1,072		20	54	54	229	62
63	HEAT EXCHANGER	2001	710		20	36	36	152	63
64	TIME CLOCK/LIGHTS AN	2001	1,395		20	70	70	292	64
65	BLOWER/IGNITOR	2001	652		20	33	33	134	65
66	COOLER	2001	1,226		20	61	61	250	66
67	EXHAUST	2002	925		20	93	93	340	67
68	GENERATOR	2002	2,018		20	202	202	740	68
69	PAINTING	2002	1,980		20	198	198	776	69
70	TOTAL (lines 4 thru 69)		$ 1,157,309	$ 27,694		$ 53,196	$ 25,502	$ 668,472	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,157,309	$ 27,694		$ 53,196	$ 25,502	$ 668,472	1
2	PAINTING	2002	700		20	70	70	268	2
3	SHELVING	2002	830		20	83	83	318	3
4	EXHAUST FAN	2002	1,525		20	153	153	598	4
5	HEAT EXCHANGER	2002	2,200		20	220	220	715	5
6	FREEZER	2002	608		20	61	61	228	6
7	COMPRESSOR	2002	618		20	62	62	248	7
8	VACUUM PUMP	2002	645		20	65	65	227	8
9	PLUMBING	2002	781		20	78	78	260	9
10	BATTERY	2002	567		20	57	57	199	10
11	CEILING TILES	2002	1,826		20	183	183	686	11
12	FIRE DOORS	2002	3,921		20	392	392	1,405	12
13	TILES	2002	1,132		20	113	113	434	13
14	PIPE	2002	550		20	55	55	197	14
15	COMPRESSOR	2002	1,483		20	148	148	531	15
16	PLUMBING	2002	629		20	63	63	241	16
17	TILE STRIP/WAX	2002	7,000		20	700	700	2,800	17
18	HVAC UNIT	2003	12,150		20	405	405	1,215	18
19	PIPING/PLUMBING	2003	5,250		20	241	241	723	19
20	SIDEWALK REMOVAL/REPAIR	2003	3,300		20	41	41	123	20
21	ELEVATOR REPAIR	2003	1,158		20	29	29	87	21
22	DOOR FRAME REPAIR	2003	679		20	28	28	84	22
23	FAN REPAIRS	2003	500		20	15	15	45	23
24	COMPRESSOR REPAIR	2003	1,065		20	40	40	120	24
25	COMPRESSOR REPAIR	2003	825		20	31	31	93	25
26	COMPRESSOR REPAIR	2003	591		20	15	15	45	26
27	CONDENSOR FAN MOTOR	2003	537		20	11	11	33	27
28	WATER HEATER	2004	5,400	138	39	138		201	28
29	NEW HEATING UNIT	2004	12,250	314	39	314		458	29
30	20 FT STORM PIPE	2004	4,500	116	39	115	(1)	168	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,230,529	$ 28,262		$ 57,122	$ 28,860	$ 681,222	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 361,202	$ 9,172	$ 36,120	$ 26,948	10	$ 226,358	71
72	Current Year Purchases	14,816	2,964	741	(2,223)	10	741	72
73	Fully Depreciated Assets	223,394				10	223,394	73
74	RELATED PARTY							74
75	TOTALS	$ 599,412	$ 12,136	$ 36,861	$ 24,725		$ 450,493	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		VAN	1998	$ 22,421	$	$	$		$ 22,421	76
77										77
78										78
79										79
80	TOTALS			$ 22,421	$	$	$		$ 22,421	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,852,362	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 40,398	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 93,983	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 53,585	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,154,136	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CAMELOT HEALTHCARE CENTER
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		211		$ 823,987			3
4	Additions							4
5								5
6								6
7	TOTAL		211		$ 823,987 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 63,144 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 6,403	$		$ 6,403	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,320			25,320	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			24,598			24,598	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				233,775		233,775	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, RENTAL, RADIOLOGY Other (specify): OTHER SVC	39-2					49,003		49,003	13
14	TOTAL			$		$ 56,321	$ 282,778		$ 339,099	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR **#** 0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 930,088	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,388,895		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	271,803		6
7	Other Prepaid Expenses	32,493		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,623,279	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,104,008		15
16	Equipment, at Historical Cost	621,836		16
17	Accumulated Depreciation (book methods)	(1,016,926)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 708,918	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,332,197	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 383,430	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	289,452		29
30	Accrued Salaries Payable	268,238		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,847		31
32	Accrued Real Estate Taxes(Sch.IX-B)	104,000		32
33	Accrued Interest Payable	191		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	REAL ESTATE TAX ESCROW	11,060		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,101,218	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,101,218	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,230,979	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,332,197	$	48

***(See instructions.)**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR **#** 0029199 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,617,234	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,617,234	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	822,457	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(208,712)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 613,745	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,230,979	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,059,575	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,059,575	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	253,003	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 253,003	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,329	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,329	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS - NET	1,973	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,973	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,316,880	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,704,924	31
32	Health Care	4,200,213	32
33	General Administration	2,083,926	33
	B. Capital Expense		
34	Ownership	1,052,928	34
	C. Ancillary Expense		
35	Special Cost Centers	339,099	35
36	Provider Participation Fee	113,333	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,494,423	40
41	**Income before Income Taxes (line 30 minus line 40)****	822,457	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 822,457	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,136	$ 67,502	$ 31.60	1
2	Assistant Director of Nursing	1,832	2,152	69,357	32.23	2
3	Registered Nurses	15,580	16,748	503,718	30.08	3
4	Licensed Practical Nurses	27,167	29,807	741,681	24.88	4
5	CNAs & Orderlies	115,023	121,125	1,279,948	10.57	5
6	CNA Trainees					6
7	Licensed Therapist	6,741	7,331	190,993	26.05	7
8	Rehab/Therapy Aides	20,211	22,205	279,401	12.58	8
9	Activity Director	1,824	2,088	38,401	18.39	9
10	Activity Assistants	13,120	14,083	144,846	10.29	10
11	Social Service Workers	3,808	4,216	91,874	21.79	11
12	Dietician					12
13	Food Service Supervisor	4,267	4,803	97,938	20.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,350	29,138	254,739	8.74	15
16	Dishwashers					16
17	Maintenance Workers	8,091	8,875	113,574	12.80	17
18	Housekeepers	32,511	35,526	335,779	9.45	18
19	Laundry	9,629	10,566	93,989	8.90	19
20	Administrator	2,024	2,080	101,585	48.84	20
21	Assistant Administrator	3,936	4,256	94,034	22.09	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,165	5,738	129,123	22.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,011	5,323	66,808	12.55	31
32	Other Health Care(specify)	10,247	11,477	316,216	27.55	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	315,433	339,673	$ 5,011,506 *	$ 14.75	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 40,030	1-3	35
36	Medical Director	MONTHLY	9,000	9-3	36
37	Medical Records Consultant	MONTHLY	4,501	10-3	37
38	Nurse Consultant	MONTHLY	30,000	10-3	38
39	Pharmacist Consultant	MONTHLY	2,149	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	MONTHLY	3,599	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 89,279		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	241	$ 10,802	10-3	50
51	Licensed Practical Nurses	4,189	155,678	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	4,430	$ 166,480		53

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JO ANNE FISHER	ADMIN		$ 101,585
KATHLEEN SEFCIK	ASST ADMIN		57,628
TRINIDAD SANDOVAL	ASST ADMIN		36,406
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 195,619

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 298,976
TOTAL (agree to Schedule V, line 17, col. 3)	$ 298,976
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK, BOKOR & KAGDA	ACCOUNTING	$ 30,000
FROST RUTTENBERG	ACCOUNTING	1,511
STONE MCGUIRE	LEGAL FEE	1,820
DUANE MORRIS	LEGAL FEE	82
HARROLD WILDMAN	LEGAL FEE	238
RICHARD PEELO	MEDICARE CONSULT	6,000
ACCU-MED	DATA PROCESSING	6,900
MUTUAL OMAHA	DATA PROCESSING	463
ADP	FLEX RETIREMENT PLAN	880
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 47,894

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 146,938
Unemployment Compensation Insurance	57,514
FICA Taxes	392,219
Employee Health Insurance	369,379
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	15,944
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	31,240
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,013,234

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	52,121
Health Care Worker Background Check	6,618
(Indicate # of checks performed 415)	
MARKETING/ADV/PROMO	13,715
TRUST/FRANCHISE/CONTRIB/ETC	550
LICENSES & PERMITS	6,383
DUES & SUBSCRIPTIONS	2,628
RELATED PARTY	276
TRUST/FRANCHISE/CONTRIB/ETC	(550)
Less: Public Relations Expense	(0)
Non-allowable advertising	(12,865)
Yellow page advertising	(850)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 69,021

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	57
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 57

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BURGESS SQUARE HEALTHCARE CTR # 0029199 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **MNS - $1,500, ILNHAA - $300**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **47,098** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **113,333**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees